PUBLIC HEALTH, WELFARE & SAFETY
Exhibit No. 6
Date 2-7-07
Bill No. SB 312

MERCURY STREET MEDICAL

February 7, 2007

Mercury Street Medical Group, PLLC
300 West Mercury
Butte, Montana 59701

Telephone (406) 723-1300
Facsimile (406) 723-1310

Re: Senate Bill 312

Dear Committee members,

I am presenting the following information because I am a proponent of legislation that will make economic credentialing (often euphemized as conflict of interest) policies from being instituted in any Montana hospital.

Certainly in Butte Montana it is not a theoretical threat but has become a reality. I have attached the letter we received as medical staff members in January 2, 2007 from James R. Kiser, the 2nd present CEO of St. James healthcare. (See attachment A)

The following information I hope will educate you regarding the harmful consequences of allowing such policies to be instituted, especially in the communities where there is a single hospital as a sole provider of in-patient services. I should emphasize as a physician I am in support of our local hospital and would like to see it succeed. I am concerned however that physician partnering economically with the hospital can represent a real conflict of interest when it comes to performance improvement assessment and patient safety. I also feel that there will be negative, unintended consequences in terms of decimating local medical staffs, devitalizing the healthcare economy in the smaller Montana communities and as previously stated, increase the risks to patient safety because of the overwhelming emphasis on "economic profitability".

The attached narrative expands on these issues and concerns.

I hope this has been informative, if you have any questions please feel free to contact me.

John Pullman, M.D. FACP
300 West Mercury
Butte, MT 59701
(406) 723-1300

"Caring for Butte"

Attachment A

St. James Healthcare

Sisters of Charity of Leavenworth Health System

January 2, 2007

Dear Medical Staff Member:

At the December 20, 2006 meeting, the Board of Directors of St. James Healthcare adopted a Conflicts of Interest Policy related to financial interests in competitive entities providing patient care services. A copy of that policy is enclosed for your information.

This policy is not intended to prohibit competition. Rather, it attempts to prevent St. James seeing only patients without the means to pay for their care, while not receiving those with the means, so that we may cross-subsidize services and thereby help ensure the viability of our hospital for you, your patients, and the community.

As you will note, the policy requires disclosure of conflicts at time of application for medical staff membership, and immediate disclosure of conflicts when they arise after the application has been approved. Therefore, I am requesting that you provide, in writing, notification of any such conflicts to the Administration Department for the Board's review.

If you have any questions about the policy and its application, please do not hesitate to contact me.

Respectfully,

James R. Kiser II

James R. Kiser II
President and CEO

JRK/llh
Enclosure

400 South Clark Street • P. O. Box 3300 • Butte, MT 59702 406-723-2500

FAXED 1/4/07 RM

St. James Healthcare	Policy Number:	I-K 17
	Department or Division:	Medical Staff Services
Date: 12/20/06 Rev. Dates:	Subject:	Conflicts of Interest Resulting from Certain Financial Interests

SUMMARY

It is the policy of St. James Healthcare, consistent with sound business practices and the principles of Organization Ethics prescribed by the 2006 and 2007 Joint Commission on Accreditation of Healthcare Organizations ("JCAHO") Standards RI.1.10 and RI.1.20, to:

- Establish and enforce ethical practices for marketing, admission, transfer, discharge, billing, and other activities involving the provision of healthcare services to the community;
- Be aware of actual and potential conflicts of interest and relationships with physicians and other entities to ensure that the hospital's mission and responsibility to patients and the community are not harmed by professional, ownership, contractual, or other relationships; and
- Address conflicts of interest arising from financial interests held by medical staff members.

Because conflicts of interest do not, in and of themselves, reflect upon the professional qualifications of clinical competence of medical staff members, they are appropriately addressed by a Board of Directors ("Board") policy, rather than by the disciplinary procedures of the Medical Staff.

POLICY

In furtherance of the above policy:

1. A conflict of interest exists when there is a divergence between an individual's private interests and the interests of the hospital, such that an independent observer might reasonably question whether the individual's actions or decisions affecting the hospital or patients might be substantially influenced by those private interests. A conflict of interest includes a direct or indirect financial interest of the individual or his/her spouse, siblings, or children in an entity that competes with the hospital in the provision of any patient care services. This policy relates to such conflicts of interest. The existence of a conflict of interest depends on the situation and not the character of the individual, and is to be determined by the Board.

2. An individual with a conflict of interest shall not have a role in the governance activities of the hospital, or have access to non-public information concerning those activities. This shall include, but not necessarily be limited to, serving as an *ex officio* member of the Board (as an officer of the medical staff or any other capacity), except with respect to matters within the purview of the medical staff in overseeing quality of care, treatment and services delivered by practitioners who are credentialed and privileged through the medical staff and Board process. This prohibition does not apply to individuals having financial interests in (a) a medical office owned and operated exclusively by the individual or his/her group practice and serving only patients of the individual or group practice; or (b) hospital-sponsored joint ventures, because the interests of hospital-sponsored joint ventures are aligned with those of the hospital.

3. A practitioner who has a conflict of interest shall not be eligible to hold medical staff membership or clinical privileges at the hospital if the conflict of interest results in economic favoritism toward the entity in which the practitioner has a financial interest, and the Board determines that the interest is inimical to the interests of the Hospital. Practitioners shall be required to disclose any financial conflict of interest as part of the initial application process, and shall have an on ongoing obligation to disclose it immediately and in writing to the Chief Executive Officer if the conflict arises after the application has been approved. A practitioner who has such an interest, or whose spouse, siblings or children have such an interest, shall bear the burden of showing that it does not result in economic favoritism. In the event of a dispute, the practitioner shall be afforded an opportunity to be heard, in such a manner as may be determined by the Board or the Chief Executive Officer on its behalf. The final determination as to whether a conflict of interest exists within the meaning and intent of the Policy, and whether it is inimical to the interests of the Hospital, shall be made by the Board, in its sole discretion. Because the existence and economic effect of a conflict of interest are not within the purview of the medical staff, the Board's determination shall not be subject to the Hearing and Appeal Procedures of the Medical Staff Bylaws.

FAXED 4/4/07 RM

St. James Healthcare

Sisters of Charity of Leavenworth Health System

January 16, 2007

Dear Medical Staff Member:

I have received requests for clarification of the Board's recent policy on conflicts of interest, and particularly on what is meant by economic favoritism toward the entity in which a practitioner has a financial interest. I am taking this opportunity to communicate the Hospital's response to the entire medical staff, in case others have similar questions.

The policy is not intended to preclude physicians from investing in private health care ventures, from making referrals to facilities in which they have an economic interest, or from providing choices to the community. Rather, it is narrowly targeted against the abuse of Hospital medical staff privileges by the use of those privileges to direct patients to or from the Hospital on the basis of payment or profitability, to the detriment of the Hospital. The Board is concerned that the effect of this kind of abuse would be to deprive the community of choice - particularly those members of the community who are unable to pay for private health care, and whom physicians have no obligation to serve in privately-owned facilities.

I hope this will alleviate any concerns about the intent of the policy. Please feel free to contact me if you have any further questions.

Sincerely,

James Kiser
President and CEO

JAN 17 2007

JK/lt

ATTACHMENT B

Over the last year a number of hospitals in Montana have asserted that organized physician groups are attempting to "harm" their local hospitals by owning certain clinical services that compete with hospitals. These hospitals have alleged that with these services physicians will "cherry pick" patients (only serve those with the best paying insurances), own only those services with the best profit margins and, by these efforts, reduce revenues and profits expected by the hospitals. These hospitals assert they'll have to cutback on necessary services and communities will suffer. Some hospitals in Montana are retaliating. A few expect to put policies in place that will remove longstanding community physicians from the hospitals' medical staffs; effectively preventing them from caring for their patients. Hospitals and community boards pursuing these tactics are sole community providers; i.e., the only hospital in the community.

On the surface it's easy to understand how sides are taken on this issue. Supporters of these hospitals see the issue from the perspective of a perceived threat. "If we don't do something drastic, our hospital will be harmed, it may be put out of business; the community will suffer." There is, however, at least one other perspective to consider. That perspective is community health care will be strengthened if physicians organize into larger, more clinically sophisticated group practices that provide a broader array of medical services to communities. Support for this perspective follows.

First, no hospitals in the U.S. have been "put out of business" because physicians have organized into larger group practices, in fact, many have become stronger as a direct result. In several communities, hospitals and larger group practices (practices of over 100 physicians and larger) have merged with community hospitals creating stronger more financially stable health systems. Second, it is the larger, organized, more clinically sophisticated group practices that are attractive to the physicians in medical training today. The physician looking for solo practice, or a small group practice opportunity is a dying breed. Fewer and fewer young physicians don't want the risk of

the small private practice for a variety of reasons including the related financial risks. An honest look at communities in Montana, where larger group practices exist, will reveal interesting truths; in many cases most of the physicians brought to the community were attracted by the large group practice. A logical question is raised. If not for the availability of the larger, organized physician group practice, how many of these physicians would have come? Second, and related, specific Montana communities have specialty-trained physicians who bring new and innovative medical techniques and programs to their communities. These "subspecialized" physicians require other highly trained physicians as partners, as well as the size and support available only from larger, organized multispecialty physician group practices to their professional activities. Would these highly trained medical specialists have come to communities as "sole practitioners"? Third, the physicians who some hospitals and community boards are organizing against live in these communities. Their families live in these communities, their employees live in these communities. Why would they wish to threaten the viability of the only hospital in the community; not to mention their own professional livelihood?

Some have argued this "fight" is only about money. Those who side with the hospitals say only the hospitals have the best interests of the communities at-heart; the physicians are the "greedy ones". Let's examine the economics of large, multispecialty medical group practices to test this "greed theory". Physicians take home, as pay, far less than half of the revenues of a large clinic. The lion's share goes to employees, supply costs, costs related to expensive technologies, property and sales tax (taxes not paid by community hospitals) and costs related to facilities and other expenses such as ongoing medical education, training and clinical research.

All larger clinics provide free care and charity care to significant levels. Established physicians fund the costs related to bring new physicians to communities and established physicians directly assume the financial risks associated with the start-up of new medical services in their clinics. The risks of large clinic growth and development in communities is born directly by the physician in these clinics.

So the question is if hospital physicians dangle the sword of hospital privileges risk over physicians in their communities, what unintended negative consequences might result:

- New physicians who might otherwise see Montana communities as an attractive place to practice seek less hostile practice environments; they go elsewhere.
- Existing, larger group practices shrink in size and scrap future plans for adding new services development. Physician recruiting plans are scrapped.
- Large group practices are forced to accelerate competition for fear their hospital privileges will be curtailed or eliminated; they'll need to develop alternative places of care for their patients.

Taking the long view on health care in Montana, especially for communities where there is only one hospital, several important questions pertain that can only be answered by reasonable people engaging in collaborative problem solving. These questions are:

- If community hospital executives and board members hold sole discretion over what is "bad" competition by local physicians and remove physicians ability to practice in the hospital, what are the longer term unintended negative consequences for the community?
- If one of these unintended negative consequences is a reduction in physician and specialty programs access and availability, what will the hospital do? Will they be driven to recruit and employ physicians? If this occurs has the competitive table turned; do hospitals then become competitors of the local independent physicians. If so, what recourse do these physicians have?
- Will hospitals that restrict physicians' hospital privileges force these physicians to build their own hospitals?

A reasoned view of the U.S. landscape should cause Montana health professionals, community boards and legislators to pause and think before taking away hospital privileges from physicians due to what is perceived to be "unfair competition." While some community hospitals in the U.S. have thought about what is commonly referred to as "economic credentialing" of physicians, most haven't because of the potential for unintended negative consequences. Perhaps because the effects of community

hospitals exerting monopoly-based powers to negatively affect the professional practices of physicians most certainly will create responses that may not, at the end of the day, benefit patients, communities, hospitals or physicians.